UNIT 4

Health System Inputs

4.1. Human resource for health (hrh)

Objective

At the end of this chapter, participants will be able to:

- Explain the role of HRH Programme in health.

Learning Activities

- ✓ Story telling about benefits of good sexual conduct
- ✓ Group discussion on consequences of sexually misbehaving
- ✓ Debate on ways and benefits of gender balance preventions

NOTES TO USERS

Under the HRH Programme, six new postgraduate residency programs in emergency medicine, neurosurgery, orthopedic surgery, pathology, psychiatry, and urology were launched in the CMHS School of Medicine and Pharmacy in 2013. The HRH Program funding proposal had planned to launch eight residencies, including family and community medicine, oncology, neurology, and radiology. However, investments to strengthen internal medicine and general surgery programs were prioritized over family and community medicine, oncology, and neurology before the start of the HRH Program, and the launch of the radiology program was delayed for 2016 (Cancedda et al., 2018; MOH, 2016). The University of Rwanda had mixed results in retention of Rwandan faculty, but showed early progress in recruiting those trained under the HRH Program. In 2019, the university revised its policies and procedures for hiring academic staff to lessen the requirements for promotion, emphasizing the importance of research, and quantifying student mentorship responsibilities (University of Rwanda, 2019).

Upgrading nurses and midwives from A2 to A1 was seen as essential to building a health workforce capable of addressing the needs of the Rwandan population and viewed as the key for "transforming care for the vast majority of people living with HIV".

Numbers of medical doctors in Rwanda

- According to the Rwanda Medical and Dental Council (RMDC) data, the newly deployed doctors add on the existing list of 1,176 general practitioners and 495 specialists in different fields. Considering an estimated population of almost 12 million, Rwanda counts an average of **1 doctor per 12,000 people**.
- Rwanda government remains under pressure to increase the number of medical doctors in the country to meet the desired international health staffing standards, despite recent increment in enrolment.
- The government has set a target of one physician per 10,000 people ratio before the year 2020. According to WHO recommendations, a minimum of 2.5 health workers per 1,000 people is fair, but the organisation's famous recommendation of one doctor per 1,000 populations is hardly met worldwide.
- According to the Ministry of Health report, the number of health facilities increased from 1,161 in 2014 to 1,221 in 2015. In 2015, the number of medical doctors was 742 from 709 in 2014 and the number of population per one doctor was 15,479 from 15,510 in 2014. Income, Expenditure and wealth: GDP per capita increased from USD 719 in 2014 to USD 720 in 2015[27].

Doctors and Nurses/Midwives in Rwanda

- A total of 21,552 health professionals are registered in Rwanda comprising of 7% (1,521) Doctors, 70% (15,050) Nurses and Midwives, 19% (4,083) Allied Health Professionals, and 4% Pharmacists and Pharmacy Technicians.
- Doctor, nurse and midwife to population density is **1.01 per 1,000 population**, 108% increase since 2005. There has been sustained improvements in the number of GPs registered in Rwanda since 2013 but records at the MOH show that since the year 2000, about 518 Rwandan Medical Specialists have been trained in various specialities out of which 13% migrated out of the country and 3% as attrition rate (death or retirement) from the labour market.
- Nurses and Midwives registered in Rwanda have more than doubled between 2013 and 2017 (218% increase).
- The number of pharmacists registered in Rwanda is growing by 22% annually since 2016. *(Source: Health labour market analysis report, MoH 2019).*

4.2. Health insurance & financing

Objective

At the end of this chapter, participants will be able to:

- Explain the benefits of population participation in health financing and adherence to the CBHI scheme.

Learning outcomes:

- Mobilize the population to adhere to the community based health insurance
- Ensure periodic revision of health insurance package

Assessment approach

- Use formal and informal procedures in gathering information on learning and making judgment about what participants know and can do and how that will change participants' attitudes. It should be an integral part of the training.
- At the beginning of the session, verify what participants already know or can do and check whether participants are at the same level.
- During the session verify if the participants understand and give support and feedback when necessary.
- At the end of the unit and the session verify if the objectives set have been achieved.
- Different techniques of assessment should be used: Questions, activities, homework etc.

Learning Activities

- ✓ Story telling about benefits of good sexual conduct
- ✓ Group discussion on consequences of sexually misbehaving
- ✓ Debate on ways and benefits of gender balance preventions

NOTES TO USERS

Strategic direction:

By 2024 Rwanda will ensure a sustainable CBHI scheme through adequate community mobilization.

Strategies:

- Ensure mass mobilisation and efficiency in the management of CBHI resources;
- Establishment of revenue generating projects across the health system Promotion of Public Private and Community Partnerships (PPCP).
- Further consolidate the pre-payment and risk pooling arrangements
- Improve the efficiency of existing health services purchasing mechanisms.

4.2.1. Health insurance

Introduction

Community Based Health Insurance (CBHI or Mutuelle de Santé): is a solidarity health insurance system in which persons (families) come together and pay contributions for the purpose of protection and receiving medical care in case of sickness.

Objective of CBHI:

- It was established in order to help people with low income access medical care at affordable cost.

Advantages of CBHI:

- A member of Community Based Health Insurance can get medical treatment cheaply at local medical facilities like health post or health centre and pays only 200Frw or just 10% of the total bill at all districts and provincial hospitals as well as referral hospitals;
- A member of Community Based Health Insurance does not become stranded at home because of quick access to health care, whenever need arises, before the sickness gets worse;
- A member of Community Based Health Insurance is assured of access to authorized medical facilities cheaply;
- A member of Community Based Health Insurance makes economic progress because of sustained health that enables a person to work hard to improve and maintain reasonable economic development and standard of living.
- Medical care is refundable by RSSB provided that the health facility has signed an agreement with RSSB. The Ministry of Health in collaboration with RSSB has agreed which medical procedures and drugs are to be refunded.

Categories of members:

- Ordinary Members: An ordinary member is any person enrolled into the Community-Based Health Insurance scheme who either personally or through a third party, pays an annual contribution. Membership is effective when each household member has, personally or through third party paid the required contribution. The Community Based Health Insurance scheme offers healthcare coverage to household members if all of them have paid their respective contributions, with the exception of any member insured under any other medical insurance scheme.
- Honorary Members: Honorary members are persons who provide support or donation without expecting any medical services or other benefits in return.

Validity of contribution:

- A member who joins for the first time the community based health insurance scheme shall starts benefiting from medical care services immediately if he/she has paid for the whole household before 30th September. When payment is done after 30th September they have to wait for one month after the payment of his/her subscription fees before benefiting.
- However, medical services for a child aged three (3) months and younger shall be covered by the child's parents' contribution. Payment of contribution is required for a child aged more than three (3) months.
- The member renews his/her insurance before the benefiting year ends. However, he/she continue to receive medical care services for thirty days (30) upon expiry of the insurance.
- The community- based health insurance scheme year starts on 1st July and end on 30th June of the following year.

Payment of contributions:

Contribution is made depending on the Ubudehe category in which individuals are:

- Category I pays 2,000Frw per person and this category is supported by the Government and other donors
- Category II pays 3,000Frw per person
- Category III pays 7,000Frw per person

The community- based health insurance scheme year starts on 1st July and end on 30th June of the following year.

Note: Category I is supported by the Government and other donors, Payment Contributions is done online via:

- Imirenge Sacco (All)
- Mobicash agents
- Irembo at all cells level or Irembo Agents
- MTN Mobile Money, Airtel Money and Tigo Cash.

The payment for the group of people (Serveral Households) is done via commercial banks and the list of people who the contributions are paid for must be submitted to the nearest RSSB Branch. Members of community based health insurance scheme receive primary medical care from health center or from a health post anywhere in the country. With exception of emergency cases, a patient benefits from medical care of health facilities of superior category if he or she has a transfer note.

4.2.2. Health financing

Learning outcomes:

- Mobilize the population to adhere to the community based health insurance
- Ensure periodic revision of health insurance package
- Ensure financial sustainability of Health sector (increase budget, optimization, efficiency, collaboration with the private sector and PPP,...)
- Promote new innovative financing mechanisms for high impact interventions and emerging diseases.

Assessment approach

- Use formal and informal procedures in gathering information on learning and making judgment about what participants know and can do and how that will change participants' attitudes. It should be an integral part of the training.
- At the beginning of the session, verify what participants already know or can do and check whether participants are at the same level.
- During the session verify if the participants understand and give support and feedback when necessary.

Objectives

At the end of the unit and the session verify if the objectives set have been achieved.

- Different techniques of assessment should be used: Questions, activities, homework etc.

Learning Activities

- ✓ Story telling about benefits of good sexual conduct
- ✓ Group discussion on consequences of sexually misbehaving
- ✓ Debate on ways and benefits of gender balance preventions

NOTES TO USERS

Introduction

Healthcare financing refers to the management of funds for these medical resources. When patients cannot pay out-of-pocket medical expenses, healthcare financing works as credit and enables them to receive care.

Strategic direction:

By 2024 Rwanda will ensure a sustainable, equitable and efficient health financing system through adequate resources mobilization.

Strategies:

- Intensify resource mobilization in order to ensure sustainability of the Rwanda health financing system
- Strengthen the current PBF Accreditation to improve quality of care in health facilities
- Promote the Rwanda Treasury and "health bond' as an innovative financing to attract social and philanthropic investment and thus unlocking additional funding for the health sector Rwanda HSSP 4
- Ensure resource mobilisation and efficiency in the management of health facilities resources by improving cost recovery and cost saving plans for health products, including blood products;
- Establishment of revenue generating projects across the health system Promotion of Public Private and Community Partnerships (PPCP).
- Further consolidate the pre-payment and risk pooling arrangements.

Rwanda health financing system

Rwanda has significantly advanced universal health coverage with its community-based health insurance (CBHI) program commonly known as Mutuelles de Santé. In Rwanda, 85% of the population seeks health services at the public, primary health center level so health centers support many citizens. In this context, the Health Financing Strategic Plan 2018-2024 will serve as an instrument to advocate for increasing the **domestic budgetary allocated to the health sector**, and ensure that funds are pooled effectively together to strategically purchase health services to ensure equitable utilisation of health services. The goal of the Health Financing and Sustainability Policy is to strengthen current health financing systems and guide the development of new initiatives and strategies to improve financial accessibility and resourcing towards a sustainable Rwandan health sector. This policy will be focused on reaching the following objectives:

- To increase efficiency for improved quality and service delivery (value for money);
- To strengthen Health Insurances and risk pooling systems;
- To enhance strategies and interventions for increasing domestic revenue for health including the community and private sector to monetize available expertise;
- To strengthen the institutional environment for sustainable financing and ensure accountability in the health sector.

4.3. Actors and stakeholders

Learning Objective :

- Adopt strategies for attracting private investors in health

Objective:

At the end of this chapter, participants will be able to:

- list different actors in health sector in order to mobilize them to support health programmes.
- to discuss the coordination of health partners through TWGs and JADF.

Learning Activities

- ✓ Story telling about benefits of good sexual conduct
- ✓ Group discussion on consequences of sexually misbehaving
- ✓ Debate on ways and benefits of gender balance preventions

4.3.1. Membership and Functions of Technical Working Groups and sub-groups

At central level, Development Partners form part of the overarching Health Sector Working Group (HSWG), which provides oversight on implementation of sector wide approach (SWAp) health actions in the entire health sector. Implementation of the deliberations of the HSWG is effected through technical working groups (TWGs). The TWGs facilitate technical dialogue on policy and operational issues between the main stakeholders (national institutions, representatives of civil society and Development Partners) involved in different programmatic areas.

Functions of the TWGs (2013) Technical Working Groups (TWG) are operational entities where technical and policy issues are discussed by MOH with its stakeholders such as Development Partners, NGOs, Private sector and Civil Society. In these fora, people participate in their technical capacity and normally represent their agencies.

The objective of the TWG is to support and advise the MOH in the implementation of sub-sector strategies and policies. All TWG operate under the authority of the Health Sector Working Group (HSWG) that is constituted of representatives of MOH, DP and civil society. All TWG (with their desks and sub-desks) are coordinated/guided by a Chair (MOH representative) and a Co-chair (Development Partners representative).

MOH distinguishes the following Technical Working Groups:

1. The MCCH Division in RBC is composed of several ‘desks’ and ‘sub-desks’, as follows:

- Maternal (including Fistula) and Child Health Units (with sub-desks in ASRH&R and Gender / Gender Based Violence)
- Family Planning Desk
- Nutrition Desk
- Community Health Desk
- Environmental Desk
- The Immunization Desk (This desk has recently been moved to RBC). Most of these desks and sub-desks work with partners in Technical Working Groups’, in which all the required technical expertise is brought together.

2. Prevention and control of Diseases, with the following ‘desks’:

- HIV and other Communicable Diseases
- Non-Communicable Disease (NCDs)
- Health Promotion and BCC
- Environmental health.

3. Treatment and control of Diseases with the desks:

- Care and Treatment
- Mental Health
- Laboratory
- Epidemic Control and Surveillance.

4. Health Systems Strengthening (HSS), with various sub-groups:

- Planning, budgeting and M&E
- HIS
- Human Resources for Health
- Health Commodities
- Health Technology including E-Health / e-Learning.
- Health Financing
- Quality of Service Delivery
- Governance and Decentralization
- Specialized Services.

5. Social mitigation with desks for:

- OVC and other vulnerable people
- Approbation of micro-projects.

6. Health Sector Research and Knowledge Management

- Operational Research
- Clinical research
- Research in social sciences.

4.3.2. Actors’ mapping

Health program is financially supported by the government of Rwanda and external resources such as financial support from bilateral organizations (USAID, ENABEL, UKAid/DFID, CDC, KOICA, JAICA) and multilateral organizations (UNFPA, UNICEF, WHO, UNAIDs, Global Fund,

East African Community,…), International NGO (Intrahealth, ADRA, Save the Children, World Vision,…), local NGOs and CSOs. There is also contribution from the private sector such telecom companies and financial business institutions.

- **Involvement of Government institutions in health programmes:** Ministry of Health, Ministry of Education, Ministry of Gender and Family Promotion, Ministry of Youth and Culture, Ministry of Finance and Economic Planning, Parliament, National youth council, Gender Monitoring Office, National Children Development agency, Districts trough District Health Management team and Joint Action Development Forum (JADF) Health Commission.
- Involvement of Development partners: through Technical Working Groups (ASRH TWG)
    - **Funding agencies:** One UN (UNFPA, UNICEF and WHO), USAID, CDC, DFID, Enabel, KOICA, JAICA ….
    - **Implementing agencies:** Local and international NGOs and Civil society organizations.

4.3.3. The role of the private sector

The private sector has a lot to offer in the attainment of UHC, but there is need to increase its engagement with the public sector through the improved Public-Private-Partnership(PPP).

At district level, the private sector will be engaged to support health systems development and expand specialized care and service provision such as: increasing availability of medical products through social marketing; building of Health Posts, malaria control through environmental measures; health education and disease prevention; health financing and support ICT for health information systems.

Together with the private sector and the community, the construction of Health Posts should be expanded to all cells to provide proper and adequate care as close to the village as possible.

4.4. Health systems research (hsr)

Learning outcome

The purpose of this session is to introduce the basic concepts and uses of health systems research (HSR).

Objectives

At the end of this session, participants should be able to:

- Define HSR, its objectives and characteristics.
- Define HSR, its objectives and characteristics.
- Describe the various uses of HSR at different situations.
- Identify, in their situation, where HSR is needed.
- Describe the general steps for undertaking HSR and how to promote the use of results.

Learning Activities

- ✓ Story telling about benefits of good sexual conduct
- ✓ Group discussion on consequences of sexually misbehaving
- ✓ Debate on ways and benefits of gender balance preventions

NOTES TO USERS

4.4.1. Why did HSR Develop?

By adopting the philosophy of and strategies for Health for All, politicians and health staff at all levels are committed to ensuring that all people will attain a level of health that enables them to participate actively in the social and economic life of the community in which they live. Although research has made major contributions to health by providing knowledge on the causes of diseases and by developing the technology to cure and prevent disease and promote health, Health for All is far from being achieved.

Some of the basic questions on which health policy-makers need information are:

- What are the health needs of (different groups of) people?
- To what extent do health interventions cover these needs?
- Can we cover more needs, more people, in a more cost-effective way?

These questions cannot be answered without collecting more information through research. That is why, in the 1970s, Health Systems Research (HSR) was developed.

During the past four decades, there has been a rapid evolution of concepts and research approaches to support managerial aspects of health development. Many of these have been described by specific terms such as operations/operational research, health services research, health management research, applied research and decision-linked research. Each of these has made crucial contributions to the development of HSR (WHO 1990).

4.4.2. Possible research questions

Health policy-makers may, for example, want to know:

- How high (or low) should user fees be for specific health services in order to prevent a drop in utilization by those who need the services most?

Managers at district level may raise questions such as:

- Why is neonatal mortality in certain districts much higher than in other districts?

Hospital directors may ask:

- Why do we observe such a high rate of complications in deliveries? Are the first-line services sufficiently available and adequate? Are our own services adequate? Are mothers coming late for delivery and, if so, why?

Managers at village level (village health committees and village health workers) may want to know:

- Why are our village health posts under-utilized?
- How can we assist illiterate women so that they can effectively prevent and treat diarrhoea?

Community leaders may want to know:

- What will be the effects of a cost-recovery programme on the cost and availability of drugs?
- How much community labour will be required to manage the new water system.

4.5. Hygiene and sanitation

Learning outcomes:

- Ensure BCC for better health promotion and prevention
- Educate population on Hygiene and sanitation
- Improve Health care waste management within the Health Facilities;
- Improve WASH services within the community- and public places
- Ensure Food Safety and Hygiene in Food Establishments
- Ensure Water Quality within the Community;
- Ensure Community Health Clubs are functional country-wide
- Improve Household sanitation and hygiene practices.

Assessment approach

- Use formal and informal procedures in gathering information on learning and making judgment about what participants know and can do and how that will change participants' attitudes. It should be an integral part of the training.
- At the beginning of the session, verify what participants already know or can do and check whether participants are at the same level.
- During the session verify if the participants understand and give support and feedback when necessary.
- At the end of the unit and the session verify if the objectives set have been achieved.
- Different techniques of assessment should be used: Questions, activities, homework etc.

Learning Activities

- ✓ Story telling about benefits of good sexual conduct
- ✓ Group discussion on consequences of sexually misbehaving
- ✓ Debate on ways and benefits of gender balance preventions

NOTES TO USERS

Strategic direction:

By 2024, the prevalence of diarrhea diseases will be reduced to 9% and the nosocomial infections reduced by half.

Strategies:

- Implement the Community-Based Environmental Health Promotion Program
- Establish geographic information platform for sharing information between sectors
- Strengthen capacity of environmental health entities from the national to the village level
- Streamline the implementation of water quality surveillance and water safety Plan, food safety, and health care waste management and injection safety, school hygiene, indoor air pollution, disaster management and preparedness, and occupational health;
- Strengthen the surveillance and reporting system for environmental health

Key innovations:

- Strengthen multi-sectoral coordination on environmental health related initiatives and geographic information sharing
- Engagement of Private sector in Health Care Waste Management
- Develop and scale innovative behavior change and social marketing strategies to increase hand washing and safely managed sanitation services.

4.5.1. Water supply

Of all services, provision of potable water is perhaps the most vital. People depend on water for drinking, cooking, washing, carrying away wastes, and other domestic needs. Water supply systems must also meet requirements for public, commercial, and industrial activities. Domestic water supply means the source and infrastructure that provides water to households. Households use water for many purposes: drinking, cooking, washing hands and body, washing clothes, cleaning cooking utensils, cleaning the house, watering animals, irrigating the garden, and often for commercial activities. A poor water supply impacts health by causing acute infectious diarrhea, repeat or chronic diarrhea episodes, and non-diarrhoeal disease, which can arise from chemical species such as arsenic and fluoride. It can also affect health by limiting productivity and the maintenance of personal hygiene. Contaminated water can harbor bacteria, such as those responsible for diarrhea, cholera, dysentery, typhoid, hepatitis A, and polio.

According to the UN, every year, approximately 297,000 children under five die from diseases linked to poor sanitation, poor hygiene, or unsafe drinking water.

4.5.2. Hygiene and sanitation for health

Hygiene and sanitation process can't be divided each other in the bakery sector. Hygiene is the purification of the environment from microorganisms causing diseases, the other hand sanitation is the measure taken for cleaning and hygiene. Sanitation is the purification of foreign substances, microorganisms, drugs, cleaning agents and all visible sources of pollution from the production environment.

- **Cleanliness** is to purify from the visible dirt in the production area by using water, air and various chemical materials in the bakery sector.
- **Hygiene** is the process of cleaning an environment from all sickness factors which may cause health problem. Hygiene process involves all the precautions to be taken in order to reduce microorganisms.

- **Sanitation** is the creation of a clean and hygienic environment and making it sustainable.

4.5.3. Wash

These three disciplines (Water Access, Sanitation, and Hygiene) commonly referred to as "WASH," can virtually eliminate waterborne diseases. The three components of WASH are grouped together because of their interdependence; one cannot be fully realized without the other. Despite Ebola and COVID-19 putting the spotlight on the importance of hand hygiene to prevent the spread of disease, three billion people worldwide, including hundreds of millions of school-going children, do not have access to handwashing facilities with soap. People living in rural areas, urban slums, disaster-prone areas and low-income communities are the most vulnerable and the most affected.

4.5.4. Rwanda's Community Based Environmental Health Promotion Programme (CBEHPP)

Rwanda's Community Based Environmental Health Promotion Programme (CBEHPP) started in 2009, with the aim to improve community health by reducing the disease burden related to inadequate sanitation, poor hygiene practices, and unsafe drinking water. Rwanda is well-known in the WASH sector for its Community Health Clubs (CHCs) and a sanitation agenda that goes beyond ending open defecation - moving people up the sanitation ladder towards basic (improved) sanitation. So far, the CBEHPP roll out relies in part on development partners, but this will not be possible for the entire country. In addition, in some districts, sanitation and hygiene are not prioritised. Overall, these factors had slowed down WASH service delivery investments at community level. Furthermore, competing priorities at district level during the implementation process (workshops and open days, awareness activities) halted progress in programme implementation and the planned schedule. The COVID-19 pandemic also limited programme field activities since mid-March 2020.

The seven targets for the CBEHPP cited in the Roadmap cover:

- Increased use of hygienic latrines in schools and homes
- Increased hand washing with soap at critical times
- Improved safe drinking water access and handling in schools and homes
- Establishment of CHCs in every village
- Zero open defecation in all villages

- Safe disposal of children's faeces in every household
- Households with bath shelters, rubbish pits, pot drying racks and clean yard (District Development plans).

4.5.5 The Community Health Clubs (CHC) Approach

CHCs is a behaviour change approach that empowers communities to address hygiene, sanitation and environmental health issues (Waterkeyn and Waterkeyn 2013; Waterkeyn and Cairncross 2005). It involves establishing "clubs" that include entire communities and promote a "culture of health", through altering norms, increasing social capital, and alignment with cultural values.

Now that parts of the country are showing fast urbanisation, CHC lack of uniformity in performance and capabilities becomes more evident. Apart from the CHC composition being predominantly made up of women (more than 90%); male membership in peri-urban and urban settings was even lower. Low male participation in CHCs likely had an impact on household decision-making on sanitation investments. Also, in peri-urban and urban areas, employed community members did not have the time for or opted out from CHC participation. And for some CHCs, the lack of land tenure discouraged the construction of household latrines, resulting in limited sanitation facilities.

More tailoring of CHC activities to different contexts as well as specifically reaching out to men, may strengthen the impact CHCs have.

Roles and responsibilities

Roles of the central government

- The central Government through MoH and MINALOC provides the oversight leadership and coordination to ensure that the sector achieves its stated goals and objectives through its programs and institutions.
- The Ministry of Health(MOH) and Rwanda Biomedical Centre(RBC) provide the technical guidance to the implementation of health policies and programmes at the various levels.

Roles of the local government

- **Governance role:** The local government ensures the provision and management of health services including financial and human resources for health facilities located in the catchment area. It also ensures the coordination, accountability,

implementation and management of health activities at decentralized level in order to improve service delivery, greater coverage of health services, improved quality, cost effectiveness and ownership.

- **Coordination:** The District Health Unit (DHU) coordinates the different actors of the health sector. It also clarifies and allocates the tasks of the different actors, and ensures an adequate integration of the multidimensional determinants of the health status of the population.
- **Awareness creation and health education:** The local government employees are mobilized to educate the general population on positive behavior change for health promotion and create awareness on health programmes for an effective community participation in prevention and management of the burden if diseases.
- **Advocacy:** The local government is called to advocate for improved joint role of the Government, Private Sector and Citizens in health sector management. The foundation for sustainable financing of the health system must be put in place at district level.
- The 2015 Health Financing and Sustainability Policy specified the key objectives that are required to take the health system in the directions outlined below:
  - To increase efficiency for improved quality and service delivery (value for money);
  - To strengthen Health Insurances and risk pooling systems;
  - To enhance strategies and interventions for increasing revenue for health including the community and private sector to monetize available expertise;
  - To strengthen the institutional environment for sustainable financing and ensure accountability in the health sector.